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Intake Report

CONFIDENTIAL

Client Name: Estabon Rodriuguez
Address: 8 Beil Drive Amityville NY, 11701
Gender: Male
DOB: 05/15/1995
Highest Level of Education: H.S. Diploma
Current Employment Status: Employed
Current Marital Status: Single
Examiner's Name: Sara Montoya

Supervisor's Name: Denise Varela, LMHC, LPC, NCC
Date of Interview: 04/18/2020
Date Report Written: 04/19/2020
Date Report Submitted: 04/22/2020

Referral and Purpose of Evaluation:

Description of Client/Behavioral Observations:
The client is a Hispanic male and is 25 years old. He is a citizen of the United States and is currently single. The client has a H.S. diploma but hopes to achieve further education. He is currently living in an apartment in his parents' house. His mother, father and 2 siblings also live in the house. The client was dressed casually. He had on jeans and a t-shirt with a hat on. The client seemed to be well groomed but seemed very restless. He did not speak much and had direct eye contact the whole session. The client was very calm and had a sarcastic sense of humor about problems he is facing. The client did seem a bit nervous and panicked when talking about his minimal hallucinations that he experiences at different moments of the day. He was overall very cooperative and willing to receive the help necessary for the purpose in which he came in for the interview. The client has not had any major surgeries but just for his appendix to be removed. The client has had prior convictions for substance abuse and was released early for good behavior. Overall the client tends to be in good health with no pre-existing conditions

Presenting Problem:
The client has expressed the stress and anxiety that he feels from "everyday life", which includes, lack of sleep, and alcohol and drug intake. The client is trying to refrain himself from substance abuse but uses it as a way to distract himself from the stress and paranoia he feels occasionally. From the paranoia the patient can occasionally experience minimal or episodes where he hallucinates "shadows" that are chasing after him. The lack of sleep can make the client feel more anxious, because of the stress of work. He describes his work environment and employer as "shitty" He receives support from his family but expresses to be independent. The client's stress and paranoia from having thoughts of something attacking him or fears of the "unknown" can keep him up until 4am and sometimes the client says he does not receive any amounts of sleep. Lastly the client expresses that he would want to take medication for his anxiety and paranoia. He has yet to take medicine and has no prior psychiatric illness.

History of the Illness and Other Relevant History:

The client was recently released from jail. He was sentenced to jail for a DUI for 2 months but was released in 3 weeks for good behavior and with the conditions of having to do community service and having a parole officer. His life has been highly affected by this conviction and has been having high levels of stress from returning to work and everyday life. The client also has episodes where he hallucinates shadows that are following him. The client expresses fear and shows panic when talking about these hallucinations. These hallucinations cause him to have different times during the day where he is paranoid. These episodes can last anywhere from 1-5 minutes where he becomes paranoid. These episodes occur in the beginning of his day and

when he tries to sleep at night. The lack of sleep influences how often these episodes can occur. The client has not been sleeping properly and tends to distract himself with consuming alcohol and drugs, specifically marijuana. The client always seemed to have a problem with getting in trouble and was highly influenced by his friends. His friends would often influence him to get high and cut class. He is the first born out of 4 children. He has 2 younger sisters and 1 younger brother. One of his sisters no longer lives in the home but visits often. He has mentioned that he has a “close knit family”. He has a Hispanic background and his parents are from El Salvador. He often visits this country and is well in touch with his culture. He has no prior history with mental health but is constantly getting in trouble and is described as the “black sheep” of the family. He has been in 2 serious relationships. 2 of those relationships were described as “toxic” and caused him some damage mentally and emotionally. One of those relationships resulted in a child. He comes from a catholic background but recently transitioned to Christian. There are no prior psychiatric illnesses from him or his family that have been reported. His father does suffer with diabetes and his grandmother died from cancer. Lastly there is no report or history of sexual or physical abuse.

Mental Status Examination:

The client presented certain concerning unusual behaviors. The client spoke in a very low monotone voice. His breathing would get heavier and seemed panicked when talking about his paranoia and hallucinations. His mood stayed the same but had sarcastic regards when it came to talk about his problems. He casually laughed at his substance intake with drugs and alcohol by saying it wasn’t a big deal. This is concerning because he got arrested for that exact reason. He is not seeing the seriousness of the situation but is willing to seek help. The client did seem to be concentrated on the session and was very responsive. The client expressed fear of the “unknown” and has anxiety about the uncertainty in his life. He did not mention anything about self- harm or hurting others. He has a delusional belief that something or someone is coming after him and living in fear. He does drink and smoke marijuana often to distract himself from the reality and delusions of his fears and uncertainty of when everything will get better for him. Lastly, the client seems to have support from his family and church. He seems to remain hopeful that everything will get better. He wants to better himself and make better decisions. He is aware of the issues that he is facing and is striving to be independent and achieve good mental health. He also has goals of owning a home and sharing a life with someone.

Clinical Formulation:

The writer should include a theoretical analysis of the current case data provided and hypotheses about the etiology of problems articulated in psychological terms. The writer should highlight symptom constellations from present and historical information, which supports a "most likely" diagnosis and tentative or working diagnoses. The writer should include the rationale that this formulation is supported by authoritative sources such as the DSM-5 or published literature (use APA style in references or quotations); highlight if there is any risk of dangerousness to self or other, and offer any reasons for tentativeness in the conclusions including the need for further assessment.

DSM-5 Diagnosis:
The writer should include all of the applicable diagnoses (full name) as per the DSM-5. The official code numbers should be provided for each diagnosis. For example:

- F32.1 Major Depressive Disorder, Single Episode (Moderate)
- F41.1 Generalized Anxiety Disorder

Tentative Treatment Plan and Goals:
In light of the tentative diagnosis and clinical data, the writer should state the professional treatment recommendation (e.g., cognitive-behavioral individual psychotherapy, dialectic behavior therapy, etc.). Additionally, the tentative short term goals of treatment should be stated (e.g., stabilize mood, reduce the frequency of panic attacks, eliminate or reduce hallucinations). Suggestions for the most appropriate form of treatment based on outcome research should be identified (use APA style in references or quotations).

Signature and Title:
The writer should include his/her signature in script, in black ink along with his/her printed full name, degree and title, state of licensure and license title, and date of signature. If the writer is an intern or partially licensed, s/he should include his/her supervisor's full name, degree, title, or position in the agency, and signature.

Appendix:
If any sources were cited in the body of the report, the writer should append a reference section. For example, a good portion of the above information can be found in the following reference:

Segal. D. (1998). Writing up the intake interview. In M. Herson, & V. B. Van Hasselt (Eds.), *Basic interviewing: A practical guide for counselors and clinicians* (pp.129-150). USA: Lawrence Erlbaum Associates.